Claims Clues

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Critical Access Hospitals May Use Bill Type 85X

AHCCCS has changed its Reference System to accept bill type 85X for services provided by critical access hospitals (CAHs). The change is effective retroactive to November 1, 2001.

Medicare requires critical access hospitals to use bill type 85X. However, because AHCCCS did not accept this bill type, claims that were crossed over to AHCCCS were denied for an invalid bill type.

Claims with an 85X bill type now will continue to process and will not be denied based solely on bill type.

CAH designation allows small rural hospitals special payment by Medicare. However, AHCCCS will continue to pay claims and process encounters consistent with the agency's hospital reimbursement methodology.

There currently are five CAH hospitals in Arizona: Benson Hospital, Northern Cochise Community Hospital, Page Hospital, Southeast Arizona Medical Center, and Wickenburg Regional Medical Center. ❒

Statute Prohibits Providers from Billing Recipients

Arizona Revised Statutes prohibit providers from billing AHCCCS-eligible recipients for AHCCCS-covered services:

ARS §36-2903.01(N) states that providers shall not "charge, submit a claim to, or demand or otherwise collect payment from a member or person who has been determined eligible" for AHCCCS.

The statute also states that providers shall not "refer or report a member or person who has been determined eligible to a collection agency or credit reporting agency for the failure of the member or person who has been determined eligible to pay charges for system-covered care or services …" ❒

Itemized Statement Required for Many Hospital Claims

Hospitals must submit an itemized statement when submitting claims to AHCCCS that will be reimbursed using the cost-to-charge methodology.

AHCCCS reimburses in-state, non-IHS hospitals for outpatient services billed on a UB-92 claim form by multiplying covered charges by the hospital-specific outpatient cost-to-charge ratio.

The statewide inpatient cost-to-charge ratio is used to reimburse outlier claims and out-of-state inpatient hospital claims.

Claims submitted without an itemized statement will be denied because Medical Review staff will not be able to verify covered charges. ❒

HIFA to Add Parents to AHCCCS Rolls in October

Beginning October 1, parents of eligible SOBRA or KidsCare children who are not otherwise eligible for Medicaid can be approved for AHCCCS coverage under a waiver approved by CMS (formerly HCFA).

The waiver is granted under the Health Insurance Flexibility and Accountability Act (HIFA). This new coverage will be funded by the unspent Title XXI KidsCare allotment.

There are potentially 70,000 to 75,000 eligible parents. However, the program will be capped at approximately 21,250 parents. Qualified individuals will be placed on a waiting list when the cap is reached.

Parents of Title XIX SOBRA children and Title XXI KidsCare children will be deemed eligible under the HIFA waiver if the following criteria are met:

- U.S. citizen or legal alien eligible for full Medicaid coverage

(Continued in Page 2)

HIFA to Add Parents to AHCCCS Rolls in October

(Continued from Page 1)

- Arizona resident
- Living with eligible child
- Has a valid Social Security Number
- Has no other creditable insurance currently or in the past three months
- Not a state employee or spouse of a state employee

Parents who do not meet U.S. citizenship or legal alien requirements will not be eligible for the Emergency Services Program under the HIFA waiver.

Eligibility and enrollment in a health plan will be prospective. There will be no retro-eligibility or Prior Period Coverage for parents covered under the waiver.

Parents, except Native Americans, will pay a premium.

The program will be implemented in two stages:

- October 1 - Parents of SOBRA/KidsCare children who are enrolled in the Premium Sharing Program
- January 1 - Parents of SOBRA/KidsCare children ❐

ASCs May Use CPT Code 41899 for Dental Services

Ambulatory surgery centers may use CPT code 41899 (Unlisted procedure, dentoalveolar structures) to bill for dental services when no other CPT code is appropriate.

Some oral surgery procedures have specific CPT codes, and these should be used by an ASC if appropriate.

CPT code 41899 has been added to the ASC Level 1 Payment Group in the AHCCCS System.

On occasion an oral surgeon may report services using 41899, but these will be manually reviewed using the procedures established for unlisted codes. ❐

Funds Approved for Non-Hospital SES Claims

The Arizona Legislature has provided limited funding to pay non-hospital claims for emergency services provided to State Emergency Services (SES) recipients.

"House Bill 1060 passed during the closing days of the recent legislative session," said Dr. C. J. Hindman, AHCCCS Chief Medical Officer. "AHCCCS now has funds to pay for non-hospital claims for emergency services provided to this group from March 21, 2002, through June 30, 2002. In addition, the Legislature did fund the SES program with $4.8 million for Fiscal Year 03, which began July 1, 2002. We will continue to pay for non-hospital emergency service claims during FY 03 as long as these appropriated funds allow."

Since March 21, AHCCCS had not made any payments to non-hospital providers for SES claims due to a lack of appropriated funds.

Hindman noted that the Legislature did not appropriate any separate funding to allow continuation of the special program for both Federal Emergency Services (FES) and SES eligible recipients who need chronic dialysis or chemotherapy/ radiotherapy and who were already on the program as of Nov. 1, 2001. There are just over 100 individuals on this special program.

"However, the state will have approximately $1 million in funds that will carry over into state fiscal year 2003 (starting July 1, 2002)," Hindman said. "These funds are currently projected to last until October, 2002."

Claims for services provided to recipients eligible under the Emergency Services Program (ESP) are reviewed by the AHCCCS Administration on a case by case basis.

For a claim to be considered for reimbursement, the services billed must meet the federal definition of emergency services:

Emergency services are services that:

- Are *medically necessary*, and
- Result from the *sudden onset* of a health condition with *acute symptoms*, and
- Which, in the absence of *immediate* medical attention, are *reasonably likely* to result in at least one of the following:
  - Placing the individual's health in *serious jeopardy*, or
  - *Serious impairment* to bodily functions, or
  - *Serious dysfunction* of any bodily organ or part.

Providers must attach supporting documentation to the claim to AHCCCS. The documentation must verify the medical emergency as defined in the federal guidelines. ❐